

		FOR OHF USE					

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**2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)**

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: <u>0029462</u> Facility Name: <u>SALINE CARE CENTER</u> Address: <u>120 SOUTH LAND</u> <u>HARRISBURG</u> <u>62946</u> <div style="display: flex; justify-content: space-around; font-size: small;"> Number City Zip Code </div> County: <u>SALINE</u> Telephone Number: <u>(618) 252-7405</u> Fax # <u>(618) 253-3418</u> IDPA ID Number: <u>37-1176175001</u> Date of Initial License for Current Owners: <u>5/15/1985</u> Type of Ownership: <div style="display: flex; justify-content: space-between;"> <div style="width: 30%;"> <input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____ </div> <div style="width: 30%;"> <input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input checked="" type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____ </div> <div style="width: 30%;"> <input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____ </div> </div>	
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In the event there are further questions about this report, please contact:
Name WILLIAM MOORMAN **Telephone Number:** (618) 993-2647

SEE ACCOUNTANTS' COMPILATION REPORT

DPA 3745 (N-4-99)

IL478-2471

Print Preview

ON, IL

Facility Name & ID Number SALINE CARE CENTER# 0029462 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	<u>142</u>	Intermediate (ICF)	<u>142</u>	<u>51,972</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>142</u>	TOTALS	<u>142</u>	<u>51,972</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF	<u>41,375</u>	<u>7,377</u>		<u>48,752</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>41,375</u>	<u>7,377</u>		<u>48,752</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4 93.80%)D. How many bed-hold days during this year were paid by Public Aid?
422 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/AF. Does the facility maintain a daily midnight census? YESG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?
YES ☒ NO ☐H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES ☐ NO ☒I. On what date did you start providing long term care at this location?
Date started 05/15/1985J. Was the facility purchased or leased after January 1, 1978?
YES ☒ Date 05/15/1985 NO ☐K. Was the facility certified for Medicare during the reporting year?
YES ☐ NO ☒ If YES, enter number
of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

MODIFIED
ACCRUAL ☒ CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 12/31/2000 Fiscal Year: 12/31/2000

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Print Preview

IF AN ERROR OCCURS IN LINE 8, 16 OR 28, PLEASE ROUND ALL CELLS IN THE APPLICABLE SECTION TO ZERO DECIMAL PLACES.

STATE OF ILLINOIS

Page 3

Facility Name & ID Number **SALINE CARE CENTER** # **0029462** Report Period Beginning: **01/01/2000** Ending: **12/31/2000**
V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	105,962	11,120	5,611	122,693		122,693	0	122,693		1
2	Food Purchase		188,885		188,885		188,885	0	188,885		2
3	Housekeeping	124,809	20,840		145,649		145,649	0	145,649		3
4	Laundry	46,038	29,049		75,087		75,087	71	75,158		4
5	Heat and Other Utilities			98,675	98,675		98,675	527	99,202		5
6	Maintenance	50,890	36,598	38,661	126,149		126,149	1,169	127,318		6
7	Other (specify): SALES TAX			2,630	2,630		2,630	(2,630)			7
8	TOTAL General Services	327,699	286,492	145,577	759,768		759,768	(863)	758,905		8
	B. Health Care and Programs										
9	Medical Director			1,422	1,422		1,422	0	1,422		9
10	Nursing and Medical Records	784,337	39,741	7,480	831,558		831,558	0	831,558		10
10a	Therapy	11,996		5,837	17,833		17,833	0	17,833		10a
11	Activities	34,407	7,984		42,391		42,391	0	42,391		11
12	Social Services	57,165		2,340	59,505		59,505	0	59,505		12
13	Nurse Aide Training							0			13
14	Program Transportation			5,410	5,410		5,410	0	5,410		14
15	Other (specify):*							0			15
16	TOTAL Health Care and Progra	887,905	47,725	22,489	958,119		958,119		958,119		16
	C. General Administration										
17	Administrative	73,656			73,656		73,656	177,422	251,078		17
18	Directors Fees							0			18
19	Professional Services			223,708	223,708		223,708	(202,130)	21,578		19
20	Dues, Fees, Subscriptions & Promotions			17,198	17,198		17,198	(8,359)	8,839		20
21	Clerical & General Office Expense	63,507	10,568	9,425	83,500		83,500	18,110	101,610		21
22	Employee Benefits & Payroll Taxes			182,435	182,435		182,435	6,470	188,905		22
23	Inservice Training & Education							0			23
24	Travel and Seminar			819	819		819	0	819		24
25	Other Admin. Staff Transportation			285	285		285	2,968	3,253		25
26	Insurance-Prop.Liab.Malpractice			23,164	23,164		23,164	294	23,458		26
27	Other (specify):*							0			27
28	TOTAL General Administration	137,163	10,568	457,034	604,765		604,765	(5,225)	599,540		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,352,767	344,785	625,100	2,322,652		2,322,652	(6,088)	2,316,564		29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000. SEE ACCOUNTANTS' COMPILATION REPORT
 NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Print Preview

IF AN ERROR OCCURS IN LINE 37 OR 44, PLEASE ROUND ALL CELLS IN THE APPLICABLE SECTION TO ZERO DECIMAL PLACES.

STATE OF ILLINOIS

Page 4

Facility Name & ID Number SALINE CARE CENTER # 0029462 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY	
		Salary/Wage	Supplies	Other	Total					9	10
	D. Ownership	1	2	3	4	5	6	7	8		
30	Depreciation			122,390	122,390		122,390	(6,888)	115,502		30
31	Amortization of Pre-Op. & Org.							0			31
32	Interest			148,023	148,023		148,023	(1,715)	146,308		32
33	Real Estate Taxes			34,084	34,084		34,084	583	34,667		33
34	Rent-Facility & Grounds							0			34
35	Rent-Equipment & Vehicles			8,250	8,250		8,250	0	8,250		35
36	Other (specify):*							0			36
37	TOTAL Ownership			312,747	312,747		312,747	(8,020)	304,727		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation							0			38
39	Ancillary Service Centers							0			39
40	Barber and Beauty Shops							0			40
41	Coffee and Gift Shops							0			41
42	Provider Participation Fee			77,958	77,958		77,958	0	77,958		42
43	Other (specify):*							0			43
44	TOTAL Special Cost Centers			77,958	77,958		77,958		77,958		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,352,767	344,785	1,015,805	2,713,357	0	2,713,357	(14,108)	2,699,249		45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

Print Preview

SEE ACCOUNTANTS' COMPILATION REPORT

FOR LINES 1 THRU 28, ENTER ONLY ONE LINE REFERENCE PER ROW. IF SIMILAR ADJUSTMENTS ARE MADE TO MORE THAN ONE LINE, ENTER THE ADDITIONAL ADJUSTMENTS ON LINE 29 OF THIS SCHEDULE AND DETAIL THEM ON PAGE 5A.

STATE OF ILLINOIS

Page 5

Facility Name & ID Number **SALINE CARE CENTER**

0029462

Report Period Beginning: **01/01/2000**

Ending: **#####**

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1 Amount	2 Refer- ence	3 OHF USE ONLY	
	NON-ALLOWABLE EXPENSES				
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Program:				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(9,783)	V-30		9
10	Interest and Other Investment Income	(1,715)	V-32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(2,630)	V-7		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(1,140)	V-20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
	Income Taxes and Illinois Personal				
26	Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(7,577)	V-20		28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (22,845)		\$	30

OHF USE ONLY							
48		49		50		51	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below. (See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	8,737		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 8,737		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (14,108)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference
38	Medically Necessary Transport		X	\$	38
39					39
40	Gift and Coffee Shops		X		40
41	Barber and Beauty Shops		X		41
42	Laboratory and Radiology		X		42
43	Prescription Drugs		X		43
44	Exceptional Care Program		X		44
45	Other-Attach Schedule		X		45
46	Other-Attach Schedule		X		46
47	TOTAL (C): (sum of lines 38-46)			\$ 0	47

SEE ACCOUNTANTS' COMPILATION REPORT

Print Preview

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.

IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Summary A

Facility Name & ID Numb SALINE CARE CENTER

0029462 Report Period Beginning:

01/01/2000

Ending: 12/31/2000

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

Print Summary
A

Operating Expenses		PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)
A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0 1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0 2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0 3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0 4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0 5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0 6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0 7
8	TOTAL General Services	0	0	0	0	0	0	0	0	0	0	0	0 8
B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0 9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0 10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0 10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0 11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0 12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0 13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0 14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0 15
16	TOTAL Health Care and Program	0	0	0	0	0	0	0	0	0	0	0	0 16
C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0 17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0 18
19	Professional Services	0	8,737	0	0	0	0	0	0	0	0	0	8,737 19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0 20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0 21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0 22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0 23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0 24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0 25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0 26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0 27
28	TOTAL General Administration	0	8,737	0	0	0	0	0	0	0	0	0	8,737 28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	0	8,737	0	0	0	0	0	0	0	0	0	8,737 29

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 3.

**SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.
IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.**

STATE OF ILLINOIS

Summary B

Facility Name & ID Number SALINE CARE CENTER

0029462

Report Period Beginning:

01/01/2000 Ending:

12/31/2000

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

Print Summary
B

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	0	0	0	0	0	0	0	0	0	0	0	0	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	0	8,737	0	0	0	0	0	0	0	0	0	8,737	45

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 4.

SEE ACCOUNTANTS' COMPILATION REPORT

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		OTHER RELATED BUSINESS ENTITIES	
Name	Ownership %	Name	City	Name	Type of Business
ROGER HERRIN	50.00%	CARRIER MILLS NURSING HOME	CARRIER MILLS,	BDK MGMT., INC.	HARRISBURG, IL
LARRY JONES	50.00%	SEVERN INTERMEDIATE CARE HOME	BUNTON, IL		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	76	77	78	79	80	81	82	83	84	85	86	87	88	89	90	91	92	93	94	95	96	97	98	99	100	101	102	103	104	105	106	107	108	109	110	111	112	113	114	115	116	117	118	119	120	121	122	123	124	125	126	127	128	129	130	131	132	133	134	135	136	137	138	139	140	141	142	143	144	145	146	147	148	149	150	151	152	153	154	155	156	157	158	159	160	161	162	163	164	165	166	167	168	169	170	171	172	173	174	175	176	177	178	179	180	181	182	183	184	185	186	187	188	189	190	191	192	193	194	195	196	197	198	199	200	201	202	203	204	205	206	207	208	209	210	211	212	213	214	215	216	217	218	219	220	221	222	223	224	225	226	227	228	229	230	231	232	233	234	235	236	237	238	239	240	241	242	243	244	245	246	247	248	249	250	251	252	253	254	255	256	257	258	259	260	261	262	263	264	265	266	267	268	269	270	271	272	273	274	275	276	277	278	279	280	281	282	283	284	285	286	287	288	289	290	291	292	293	294	295	296	297	298	299	300	301	302	303	304	305	306	307	308	309	310	311	312	313	314	315	316	317	318	319	320	321	322	323	324	325	326	327	328	329	330	331	332	333	334	335	336	337	338	339	340	341	342	343	344	345	346	347	348	349	350	351	352	353	354	355	356	357	358	359	360	361	362	363	364	365	366	367	368	369	370	371	372	373	374	375	376	377	378	379	380	381	382	383	384	385	386	387	388	389	390	391	392	393	394	395	396	397	398	399	400	401	402	403	404	405	406	407	408	409	410	411	412	413	414	415	416	417	418	419	420	421	422	423	424	425	426	427	428	429	430	431	432	433	434	435	436	437	438	439	440	441	442	443	444	445	446	447	448	449	450	451	452	453	454	455	456	457	458	459	460	461	462	463	464	465	466	467	468	469	470	471	472	473	474	475	476	477	478	479	480	481	482	483	484	485	486	487	488	489	490	491	492	493	494	495	496	497	498	499	500	501	502	503	504	505	506	507	508	509	510	511	512	513	514	515	516	517	518	519	520	521	522	523	524	525	526	527	528	529	530	531	532	533	534	535	536	537	538	539	540	541	542	543	544	545	546	547	548	549	550	551	552	553	554	555	556	557	558	559	560	561	562	563	564	565	566	567	568	569	570	571	572	573	574	575	576	577	578	579	580	581	582	583	584	585	586	587	588	589	590	591	592	593	594	595	596	597	598	599	600	601	602	603	604	605	606	607	608	609	610	611	612	613	614	615	616	617	618	619	620	621	622	623	624	625	626	627	628	629	630	631	632	633	634	635	636	637	638	639	640	641	642	643	644	645	646	647	648	649	650	651	652	653	654	655	656	657	658	659	660	661	662	663	664	665	666	667	668	669	670	671	672	673	674	675	676	677	678	679	680	681	682	683	684	685	686	687	688	689	690	691	692	693	694	695	696	697	698	699	700	701	702	703	704	705	706	707	708	709	710	711	712	713	714	715	716	717	718	719	720	721	722	723	724	725	726	727	728	729	730	731	732	733	734	735	736	737	738	739	740	741	742	743	744	745	746	747	748	749	750	751	752	753	754	755	756	757	758	759	760	761	762	763	764	765	766	767	768	769	770	771	772	773	774	775	776	777	778	779	780	781	782	783	784	785	786	787	788	789	790	791	792	793	794	795	796	797	798	799	800	801	802	803	804	805	806	807	808	809	810	811	812	813	814	815	816	817	818	819	820	821	822	823	824	825	826	827	828	829	830	831	832	833	834	835	836	837	838	839	840	841	842	843	844	845	846	847	848	849	850	851	852	853	854	855	856	857	858	859	860	861	862	863	864	865	866	867	868	869	870	871	872	873	874	875	876	877	878	879	880	881	882	883	884	885	886	887	888	889	890	891	892	893	894	895	896	897	898	899	900	901	902	903	904	905	906	907	908	909	910	911	912	913	914	915	916	917	918	919	920	921	922	923	924	925	926	927	928	929	930	931	932	933	934	935	936	937	938	939	940	941	942	943	944	945	946	947	948	949	950	951	952	953	954	955	956	957	958	959	960	961	962	963	964	965	966	967	968	969	970	971	972	973	974	975	976	977	978	979	980	981	982	983	984	985	986	987	988	989	990	991	992	993	994	995	996	997	998	999	1000
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	76	77	78	79	80	81	82	83	84	85	86	87	88	89	90	91	92	93	94	95	96	97	98	99	100	101	102	103	104	105	106	107	108	109	110	111	112	113	114	115	116	117	118	119	120	121	122	123	124	125	126	127	128	129	130	131	132	133	134	135	136	137	138	139	140	141	142	143	144	145	146	147	148	149	150	151	152	153	154	155	156	157	158	159	160	161	162	163	164	165	166	167	168	169	170	171	172	173	174	175	176	177	178	179	180	181	182	183	184	185	186	187	188	189	190	191	192	193	194	195	196	197	198	199	200	201	202	203	204	205	206	207	208	209	210	211	212	213	214	215	216	217	218	219	220	221	222	223	224	225	226	227	228	229	230	231	232	233	234	235	236	237	238	239	240	241	242	243	244	245	246	247	248	249	250	251	252	253	254	255	256	257	258	259	260	261	262	263	264	265	266	267	268	269	270	271	272	273	274	275	276	277	278	279	280	281	282	283	284	285	286	287	288	289	290	291	292	293	294	295	296	297	298	299	300	301	302	303	304	305	306	307	308	309	310	311	312	313	314	315	316	317	318	319	320	321	322	323	324	325	326	327	328	329	330	331	332	333	334	335	336	337	338	339	340	341	342	343	344	345	346	347	348	349	350	351	352	353	354	355	356	357	358	359	360	361	362	363	364	365	366	367	368	369	370	371	372	373	374	375	376	377	378	379	380	381	382	383	384	385	386	387	388	389	390	391	392	393	394	395	396	397	398	399	400	401	402	403	404	405	406	407	408	409	410	411	412	413	414	415	416	417	418	419	420	421	422	423	424	425	426	427	428	429	430	431	432	433	434	435	436	437	438	439	440	441	442	443	444	445	446	447	448	449	450	451	452	453	454	455	456	457	458	459	460	461	462	463	464	465	466	467	468	469	470	471	472	473	474	475	476	477	478	479	480	481	482	483	484	485	486	487	488	489	490	491	492	493	494	495	496	497	498	499	500	501	502	503	504	505	506	507	508	509	510	511	512	513	514	515	516	517	518	519	520	521	522	523	524	525	526	527	528	529	530	531	532	533	534	535	536	537	538	539	540	541	542	543	544	545	546	547	548	549	550	551	552	553	554	555	556	557	558	559	560	561	562	563	564	565	566	567	568	569	570	571	572	573	574																																																																																																																																																																																																																																																																																																																																																																																																																																										

* Total must agree with the amount recorded on line 34 of Schedule V SEE ACCOUNTANTS' COMPILATION REPORT!
DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

Sum_6

8737

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[illegible]

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	DR. ROGER HERRIN	PARTNER	MANAGER	50.00%	224,078	20	29.00%	MGMT FEES	\$ 177,422	17-7	1
2	DR. LARRY JONES	PARTNER	CONSULTANT	50.00%	3,300	VARIOUS	VARIOUS	PHYS. FEES	2,052	19-3	2
3											3
4											4
5											5
6	(1) SEE ATTACHED SCHEDULE										6
7											7
8	(2) FROM MANAGEMENT EXPENSES ALLOCATION SCHEDULE										8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 179,474		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORT

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees) FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

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| the name(s)
PORTS.

Facility Name & ID Number SALINE CARE CENTER# 0029462 Report Period Beginning: 01/01/2000Ending: 1/31/2000

VIII. ALLOCATION OF INDIRECT COSTS

Show Pgs 8A thru 8D

Show Pgs 8E thru 8I

Hide Pgs 8A thru 8I

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Print Preview

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related Long-Term												
1	UNION PLANTERS BANK		X	LOAN CONSOL. & RENOV	\$20,000.00	5/25/1997	\$ 2,200,000	\$ 1,621,178	6/25/2010	9.00%	\$ 148,023	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related				\$20,000.00		\$ 2,200,000	\$ 1,621,178			\$ 148,023	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$ 2,200,000	\$ 1,621,178			\$ 148,023	15	

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.

(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.

(See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

Print Preview

(1) VARIABLE INTEREST RATE IS 9.00% AT 12/31/00.

Facility Name & ID Number: **SALINE CARE CENTER**# **0029462** Report Period Beginning: **01/01/2000** Ending: **12/31/2000****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

1. Real Estate Tax accrual used on 1999 report.	\$	31,451	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	\$	33,203	2
3. Under or (over) accrual (line 2 minus line 1).	\$	1,752	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	32,915	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	\$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6	\$	34,667	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	1995	27,487	8		
	1996	27,680	9		
	1997	32,688	10		
	1998	32,320	11		
	1999	33,203	12		

	FOR OFF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 1999	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATIO	\$	16

(1) INCLUDES \$ 583 FROM ALLOCATION OF MGMT EXPENSES

ADJUSTED IN COLUMN 7.

ACCRUAL BASED ON 1999 TAXES ACTUALLY PAID.

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

SEE ACCOUNTANTS' COMPILATION REPORT

Print Preview

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 37,506 B. General Construction Type: Exterior BRICK Frame MASONRY BRICK Number of Stories 1

C. Does the Operating Entity? ☒ (a) Own the Facility ☐ (b) Rent from a Related Organization. ☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? ☒ (a) Own the Equipment ☐ (b) Rent equipment from a Related Organization. ☐ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? ☐ YES ☒ NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	FACILITY USE	514,920	1985	\$ 50,000	1
2	NURSING HOME ADMIN. (1)	4,697	1993	8,397	2
3	TOTALS	519,617		\$ 58,397	3

SEE ACCOUNTANTS' COMPILATION REPORT

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(1) FROM ALLOCATION OF HOME OFFICE ASSETS - SEE ATTACHED SCHEDULE.

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE
REMOVE THE TEXT FROM COLUMN 2 OR 3.

Show Pgs 12A & 12B

Show Pgs 12C and 12D

Hide Pgs 12A thru 12D

STATE OF ILLINOIS

Page 12

Facility Name & ID Number SALINE CARE CENTER

0029462

Report Period Beginning:

01/01/200(Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	124		1985	1969	\$ 1,230,310	\$ 51,310	30	\$ 41,010	\$ (10,300)	\$ 640,781	4
5	18		1992	1992	700,233	21,745	30	23,341	1,596	190,867	5
6											6
7											7
8											8
	Improvement Type**										
9	IMPROVEMENTS			1985	131,167	6,821	10		(6,821)	131,167	9
10	IMPROVEMENTS-ROOF/FLOOR REPAIR			1986	69,020	4,313	10		(4,313)	69,020	10
11	IMPROVEMENTS-GARAGE			1986	10,992	572	15	733	161	10,374	11
12	IMPROVEMENTS-FENCE			1986	801	42	8		(42)	801	12
13	IMPROVEMENTS-CARPET & TILE			1987	1,392		5			1,392	13
14	IMPROVEMENTS-FLOORING			1987	2,209	71	10		(71)	2,209	14
15	IMPROVEMENTS-A/C & HEATER			1987	3,348	84	8		(84)	3,348	15
16	IMPROVEMENTS-AIR FILTER/FAN			1987	101		15	7	7	95	16
17	IMPROVEMENTS-ASPHALT			1988	15,938	930	10		(930)	15,938	17
18	IMPROVEMENTS-LANDSCAPING			1992	10,381	560	15	692	132	5,594	18
19	IMPROVEMENTS-ALLOCATION (1)			1993	48,138	1,248	30	1,605	357	10,482	19
20	IMPROVEMENTS-CARPORT			1994	1,859	48	30	62	14	434	20
21	IMPROVEMENTS-ALLOCATION (1)			1994	2,080	72	30	69	(3)	399	21
22	IMPROVEMENTS-ALLOCATION (1)			1996	77	5	30	3	(2)	12	22
23	IMPROVEMENTS-ROOF			1997	14,650	376	39	488	112	1,952	23
24	IMPROVEMENTS-STORAGE BLDG.			1998	4,244	109	39	109		327	24
25	IMPROVEMENTS-GARAGE DOOR			1998	313	10	39	8	(2)	24	25
26	IMPROVEMENTS-ALLOCATION (1)			1998	350	9	30	12	3	34	26
27	IMPROVEMENTS-ROOF			2000	55,245	1,241	39	1,417	176	1,417	27
28	IMPROVEMENTS-CARPET & ACCOUS WALL COVER			2000	17,037	2,434	7	2,434		2,434	28
29	IMPROVEMENTS-ALLOCATION (1)			2000	7,733	265	30	258	(7)	258	29
30											30
31											31
32											32
33	(1) FROM ALLOCATION OF HOME OFFICE ASSETS										33
34	SEE ATTACHED SCHEDULE										34
35											35
36	TOTAL (lines 4 thru 35)				\$ 2,327,618	\$ 92,265		\$ 72,248	\$ (20,017)	\$ 1,089,359	36

*Total beds on this schedule must agree with page 2.

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

Facility Name & ID Number SALINE CARE CENTER# 0029462Report Period Beginning: 01/01/2000 Ending: 12/31/2000**XI. OWNERSHIP COSTS (continued)****C. Equipment Depreciation-Excluding Transportation. (See instructions.)**

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Componen Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	\$ 351,797	\$ 25,976	\$ 35,180	\$ 9,204	10	\$ 162,592	37
38	Current Year Purchases	14,484	2,370	1,448	(922)	10	1,448	38
39	Fully Depreciated Assets	200,951				10	200,951	39
40								40
41	TOTALS	\$ 567,232	\$ 28,346	\$ 36,628	\$ 8,282		\$ 364,991	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42	TRAVEL	1995 MERCEDES BENZ	1995	\$ 37,050	\$ 785	\$ 0	\$ (785)	4	\$ 37,050	42
43	TRANSPORT PATIENT	1998 FORD SUPERWAGON	1998	26,502	5,088	6,626	1,538	4	19,878	43
44	TRANSPORT PATIENT	1993 FORD AEROSTAR	1994	14,377	0	0		4	14,377	44
45	HAULING MAINT.	1988 CHEVY S10	1994	3,841	0	0		4	3,841	45
46	TOTALS			\$ 81,770	\$ 5,873	\$ 6,626	\$ 753		\$ 75,146	46

E. Summary of Care-Related Assets

	1	2	
	Reference	Amount	
47	Total Historical Cost (line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	\$ 3,042,429	47
48	Current Book Depreciation (line 36,col.5 + line 41,col.2 + line 46,col.5)	\$ 126,484	48
49	Straight Line Depreciation (line 36,col.7 + line 41,col.3 + line 46,col.6)	\$ 115,502	49
50	Adjustments (line 36,col.8 + line 41,col.4 + line 46,col.7)	\$ (10,982)	50
51	Accumulated Depreciation (line 36,col.9 + line 41,col.6 + line 46,col.9)	\$ 1,536,908	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52	LAND	\$ (30,000)	\$	\$	52
53	BUILDING	(243,579)			53
54	EQUIPMENT & VEHICLES	267,062			54
55					55
56					56
57	TOTALS	\$ (6,517)	\$	\$	57

G. Construction-in-Progress

	Description	Cost	
58		\$	58
59			59
60			60
61		\$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

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XII. RENTAL COSTS**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: _____

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? _____

If NO, see instructions.

☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34. _____

This amount was calculated by dividing the total amount to be amortized _____
by the length of the lease _____.9. Option to Buy: ☐ YES ☐ NO Terms: _____ ***B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)**15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO16. Rental Amount for movable equipm: \$ 8,250 Description: MISC. EQUIPMENT

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. /2001 \$ _____13. /2002 \$ _____14. /2003 \$ _____

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

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Facility Name & ID Number SALINE CARE CENTER# 0029462

Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)**A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)**1. HAVE YOU TRAINED AIDES
DURING THIS REPORT
PERIOD?☐ YES☒ NOIf "yes", please complete the remainder
of this schedule. If "no", provide an
explanation as to why this training was
not necessary.

No additional training deemed necessary during current period.

2. CLASSROOM PORTION:IN-HOUSE PROGRAM ☐IN OTHER FACILITY ☐COMMUNITY COLLEGE ☐

HOURS PER AIDE _____

3. CLINICAL PORTION:IN-HOUSE PROGRAM ☐IN OTHER FACILITY ☐

HOURS PER AIDE _____

B. EXPENSES**ALLOCATION OF COSTS (d)**

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities

\$ **D. NUMBER OF AIDES TRAINED**

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

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Facility Name & ID Number SALINE CARE CENTER# 0029462 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

1		2		3		4		5		6		7		8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)						
			Units of Service	Cost	Units	Cost									
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1					
2	Licensed Speech and Language Development Therapist		hrs							2					
3	Licensed Recreational Therapist		hrs							3					
4	Licensed Physical Therapist		hrs							4					
5	Physician Care		visits							5					
6	Dental Care		visits							6					
7	Work Related Program		hrs							7					
8	Habilitation		hrs							8					
9	Pharmacy		# of prescripts							9					
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10					
11	Academic Education		hrs							11					
12	Exceptional Care Program									12					
13	Other (specify):									13					
14	TOTAL			\$		\$	\$		\$	14					

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

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STATE OF ILLINOIS

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Facility Name & ID Number SALINE CARE CENTER

0029462

Report Period Beginning: 01/01/2000

Ending:

12/31/2000

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2000 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 176,409	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 0)	407,825		3
4	Supply Inventory (priced COST)	3,500		4
5	Short-Term Investments			5
6	Prepaid Insurance	27,697		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 615,431	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	20,000		13
14	Buildings, at Historical Cost	2,055,189		14
15	Leasehold Improvements, at Historical Cost	42,561		15
16	Equipment, at Historical Cost	808,936		16
17	Accumulated Depreciation (book methods)	(1,956,943)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	30,000		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(30,000)		20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):	100		22
23	Other(specify): LOAN FEE NET OF AMORT.	1,778		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 971,621	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,587,052	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 46,548	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	96,027		29
30	Accrued Salaries Payable	48,274		30
31	Accrued Taxes Payable (excluding real estate taxes)	5,797		31
32	Accrued Real Estate Taxes(Sch.IX-B)	33,202		32
33	Accrued Interest Payable	2,432		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	ACCRUED MGMT. FEES	32,541		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 264,821	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	1,525,151		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 1,525,151	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,789,972	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (202,920)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,587,052	\$	48

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*(See instructions.)

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XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (332,230)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (332,230)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	669,310	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(540,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 129,310	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (202,920)	24 *

* This must agree with page 17, line 47.

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XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 3,380,952	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,380,952	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,715	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,715	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,382,667	30

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	\$ 759,768	31
32	Health Care	958,119	32
33	General Administration	604,765	33
	B. Capital Expense		
34	Ownership	312,747	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	77,958	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,713,357	40
41	Income before Income Taxes (line 30 minus line 40)**	669,310	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 669,310	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation. SEE ATTACHED SCHEDULE

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT

**** Provide a detailed breakdown of "Other Revenue" on an attached sheet.

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XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,833	2,921	\$ 49,223	\$ 16.85	1
2	Assistant Director of Nursing	2,518	2,596	41,269	15.90	2
3	Registered Nurses	2,288	2,335	28,352	12.14	3
4	Licensed Practical Nurses	23,910	25,168	202,605	8.05	4
5	Nurse Aides & Orderlies	64,419	66,411	462,888	6.97	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,799	1,874	11,996	6.40	8
9	Activity Director	1,889	1,991	12,344	6.20	9
10	Activity Assistants	3,652	3,804	22,063	5.80	10
11	Social Service Workers	7,520	7,673	57,165	7.45	11
12	Dietician					12
13	Food Service Supervisor	1,974	2,076	16,726	8.06	13
14	Head Cook	2,778	2,864	16,554	5.78	14
15	Cook Helpers/Assistants	12,557	12,684	72,682	5.73	15
16	Dishwashers					16
17	Maintenance Workers	5,132	5,460	50,890	9.32	17
18	Housekeepers	20,802	21,445	124,809	5.82	18
19	Laundry	8,006	8,340	46,038	5.52	19
20	Administrator	2,000	2,080	45,002	21.64	20
21	Assistant Administrator					21
22	Other Administrative	1,564	1,564	28,654	18.32	22
23	Office Manager					23
24	Clerical	8,313	8,570	63,507	7.41	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	173,954	179,856	\$ 1,352,767 *	\$ 7.52	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	155	\$ 5,611	1-3	35
36	Medical Director	AS NEEDED	1,422	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant	104	3,400	10a-3	40
41	Occupational Therapy Consultant	72	2,437	10a-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	45	2,340	12-3	45
46	Other(specify)				46
47	CLINICAL PSYCHOLOGIST	68	7,480	10-3	47
48					48
49	TOTAL (lines 35 - 48)	444	\$ 22,690		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		\$		53

SEE ACCOUNTANTS' COMPILATION REPORT

(1) SEE ATTACHED SCHEDULE AND COPIES OF INVOICES